MEDICARE PAYMENT ADVISORY COMMISSION

PUBLIC MEETING

The Horizon Ballroom
Ronald Reagan Building
International Trade Center
1300 Pennsylvania Avenue, N.W.
Washington, D.C.

Thursday, January 16, 2003

9:14 a.m.

COMMISSIONERS PRESENT:

GLENN M. HACKBARTH, Chair
ROBERT D. REISCHAUER, Ph.D., Vice Chair
NANCY ANN DePARLE
DAVID DURENBERGER
ALLEN FEEZOR
RALPH W. MULLER
ALAN R. NELSON, M.D.
JOSEPH P. NEWHOUSE, Ph.D.
CAROL RAPHAEL
ALICE ROSENBLATT
JOHN W. ROWE, M.D.
DAVID A. SMITH
RAY A. STOWERS, D.O.
MARY K. WAKEFIELD, Ph.D.
NICHOLAS J. WOLTER, M.D.

AGENDA ITEM: PPS for psychiatric facilities
-- Sally Kaplan

MR. HACKBARTH: Okay, let's get started.

Dr. Rowe wishes to be recognized.

DR. ROWE: We've had some discussion about now that we have voted against the staff's recommendation on IME, and everyone in the world knows about that, we do have a very nice piece of analytical work and we do feel that it is appropriate for us -- or I feel, let me not try to represent the chairman or the commission -- but it seems that rather than just present the analytics without any recommendation that there should be some policy oriented statement, even if it doesn't take the form of a recommendation that is in fact voted on and specifically formally offered to Congress.

There's also agreement, I think, that there is some disagreement on almost all aspects of this. There's hardly anything we can say from a policy point of view that there would be agreement on uniformly around the table. But there are some consensus items.

I've worked a little bit on trying to put the thoughts that I offered yesterday in the context of that and would like to offer a statement for consideration for inclusion. I don't think this is something we need to vote on but we get a sense of whether this seems reasonable.

First, [inaudible] goals that hospitals may be engaged. There was a fair amount of concern about that. It doesn't say it shouldn't be there, but it certainly is not tied to anything they spend or anything they accomplish. It's just there.

That despite this there was not a consensus in this commission to reduce the IME to the empirical level at this time. That the commission will be examining this issue and calls for a robust and prompt assessment of the resources needed by hospitals to strengthen their educational programs, to keep pace with changes in health care delivery, and the evolving needs of the Medicare beneficiaries. There's also broad recognition of the need for hospitals to improve the quality of care.

Medicare support is appropriate for explicit expenditures that yield needed enhancements in medical education and quality of care. This is another way of saying that the empirical level may, in fact, be redefined to include these expenditures once they're identified.

And that the commission plans to revisit this issue promptly, so that our lack of a specific recommendation should just be interpreted as the more we

thought about it the more work we have to do on it.

That would be a sort of a general statement that I would propose be included in the report. Thank you, Glenn.

MR. HACKBARTH: What I'd like to do is, in particular, hear from commissioners who yesterday voted no on the staff and chairman's recommendation. What I don't want to do is be seen as trying to rework this issue and get around the majority of the commission. So if there are commissioners who yesterday voted no who would like to speak to Jack's comments, I'd like to hear from them first.

DR. ROWE: I voted no and I support this.

MR. HACKBARTH: Yes, I realize that. Alan Nelson, Nancy-Ann, David.

DR. NELSON: I think that's an excellent job, Jack, and I support it.

MS. DePARLE: I voted no yesterday and I appreciate the opportunity, Mr. Chairman, to discuss it a little bit more today.

I voted no because I wanted to vote yes on Jack's substitute motion which would have coupled the reduction in IME above the empirical level to requiring in an accountable fashion the academic health centers and those who receive the IME payments to improve quality and to improve the quality of education and make sure that they're including interdisciplinary approaches, such as including nurses, in the training.

And so speaking just for myself, I would not want that vote against the staff recommendation, the chairman's mark, yesterday to be misinterpreted as support for what I view as a continued subsidy that is not targeted that I don't think we can -- that I cannot support. And I hope that we'll continue to work on this and be able to vote on something like Jack's motion in the future.

MR. SMITH: Thank you, Glenn.

Jack, I appreciate both the impulse and the work and the thrust of where I think you think we ought to head seems to me to be right. But I am concerned and in just my quick notes about your proposal about what I would guess would be the fourth point, where you argue that Medicare support is appropriate, I would like to make sure that in the drafting of that point it's cast rather widely, that it is not cast narrowly within -- so that it suggests that all we're talking about here is perhaps an expansion of the activities that would fit in the empirical level of IME, but something more to the effect that Medicare support is appropriate for initiatives that because they promise widespread impacts on the health care system promise widespread benefits including those -- as the health system

improves they promise benefits that flow to Medicare beneficiaries.

But I'd not like to prematurely -- and I think for many of the reasons that some of us voted against the staff's proposal yesterday -- I don't think we're ready and I don't think there's consensus around this table that IME means a narrowly construed definition of support for specifically identified traditional or new educational activities. The kinds of things that Alan and Nick and I and others, Sheila, talked about yesterday that IME supports poorly, Nancy -- and I agree, it supports them in a way where we don't have a good sense of what we're buying, we don't have a good handle on the quality of the product that we're buying. Those are concerns.

But I wouldn't like to suggest that those things that we are buying, however badly the current system both purchases and accounts for them, we ought to stop buying.

So Jack, as we think about this language -- and I'm not sure I'm right about point four -- but if it is point four in your suggestion, I like to write that broadly rather than narrowly and then I think we might find something we could agree on.

MR. HACKBARTH: Just a word about the process, what I would envision is that we not try to wordsmith the language now, but after hearing the discussion we'll put together something that we'll circulate to all the commissioners and give people a chance to react to.

MR. FEEZOR: I, too, voted against the staff recommendation yesterday, not for lack of respect for a lot of the work and it was very consistent with what this body has been thinking, I think Nancy-Ann is right on target there. I, however, do feel and have made it expressed that we need to begin to change some dynamics in how health care is delivered, how professionals see themselves, and indeed how people access care both in the commercial and Medicare.

So I was particularly excited by Jack's epiphany yesterday. I think that we are wise in continuing to look at alternatives in terms of just how that might be structured. And I guess I would reinforce I think what David's comments were, that if we are talking about trying to re-channel some of these monies that it, in fact, do be more broadly defined. The term quality, I know, is usually broadly defined. But I think in terms of effectiveness, maybe even efficiencies in the care and delivery, and also that if we're talking about education that we not be confined strictly to the education of a physician but there are other caregivers that we are in shortage areas now that we need to give some attention to, as well.

MR. MULLER: I think the appropriate concern for accountability is clearly one that we all share. I think the kind of contributions that teaching hospitals make to the American health system along the lines that have just been mentioned has been well recognized for years. And I think it's appropriate in each generation to kind of redefine what that contribution is to meet the kind of emerging needs of the nation so we're not just, as some people said yesterday, trying to lock ourselves into whatever the conception might have been in 1983.

So I share and support Jack's sense that it's appropriate now to redefine those accountabilities that teaching hospitals take on for this payment.

I'm also concerned, as I said yesterday, that we have too narrow a definition at the empirical level. I tried to express my thoughts about that yesterday. We tie it to the number of residents in a hospital which is the means by which we distribute these IME payments. And then we get ourselves, I think, caught in the trap of saying that's all we support with IME and therefore it's a subsidy. I think we kind of get caught in that circular argument and then we say we have to get rid of the subsidy and I do reject that because I think all of us know, who have been around these teaching hospitals, it's not just the presence of residents. It's the presence of the faculty, of fellows, of nurses, of many skilled professionals that are brought together and make up these excellent medical centers that make the kind of contributions that have been supported by this program for many years.

So I'm hesitant to keep agreeing to say this is the empirical level and everything else about that is the subsidy. I think we therefore get ourselves caught into defending a subsidy that I think we too narrowly define. And then like all subsidies, they have to be justified and we have to talk our way into a way of saying it's inappropriate.

So I'm not willing to agree that the empirical level is the correct specification. I'm quite willing to agree that that's what we pay for. We pay for residents right now and then we measure the role of residents in an equation.

I know that may be too narrow a point, but I think it leads us constantly to then feeling with have to justify or make that subsidy go away. And I do think it's a broader definition of the teaching hospitals beyond just the number of residents that there are in hospital.

I would then say, on top of that, I fully endorse the sense that with a broad concern that both the Congress,

the commission, and other people have about the accountability of hospitals that we should, in fact, be looking at out that accountability can be redefined and justified going forward. So I'm in favor of a process that allows us to do that.

I'm very impressed by the level of attention that the staff and the rest of the commission has put into this, so I'm a little worried about trying to do something in a day or two when this has been discussed for years, to think that we could deal with the complexity of this issue in a day or two or a meeting or two.

So I am both in favor of looking at this but hesitant to say that we should kind of figure this out today or tomorrow. But I am fully committed to working with the rest of you on having an appropriate rationale and understanding of what the contributions this IME adjustment makes to the health care system. And I think we should be working on that.

DR. STOWERS: I also, as you know, voted against it. I'm like Nancy, I would have voted for the other, second one, even though it would have continued to reduce it down eventually to the empiric value. My problem was that it be done in isolation. And I'm not going to repeat everything that's been said because I totally agree, is that I think this is a great opportunity for the commission to look at redirecting those funds. And I totally agree with the fact that the lack of direction that's there now is inappropriate for those dollars.

But as far as the education and the quality, and I think we even still need to deal with the uncompensated care issue that some of these institutions deliver. Maybe it's not through these dollars but through some mechanism. That needs to be dealt with. So I agree also that we need to take the time and do this right if we're going to do it. Thank you.

MS. RAPHAEL: I voted no and, in general, there are certain principles in what Jack said that I very much support, among which is better targeting the dollars, trying to invest in the future, and rethink how we better prepare workforce and models for what we think that future will be.

But my only kind of concerns are what will this amount to in terms of better care for Medicare beneficiaries? We can kind of open up another industry here of people developing many different proposals that will basically represent improvements in quality, new systems et cetera.

But I think today everyone is working on quality. We're all struggling with how to deal with improving

outcomes, how to produce better quality. And a lot of the issues are very complicated and they cross parts of the health care system. I mean, a lot of the breakdowns occur between different elements of the health care system.

So I really think that thought has to be given as to what we're going to target these dollars to and how we can avoid kind of setting in motion another situation where we end up in a decade or two -- when we won't all be here but others will -- kind of looking back and saying what have we wrought? And here once again we have a certain amount of dollars going and we're not clear what we have purchased and how we can demonstrate what we have purchased.

So that's the area that I still feel we really need to spend some time on thinking through because we have education, we have quality, we have uncompensated care, we have enhanced patient care. There's a lot brewing in this mix that I think we need to kind of put under the microscope.

MR. HACKBARTH: Are there any other commissioners that voted no yesterday that want to speak to this?

We do have a full agenda for this morning, so we need to move ahead. Joe, I know you were not on the no side, but you have the final word on this.

DR. NEWHOUSE: I was originally not going to say anything but I wanted to respond to Ralph and then I wanted to say something maybe that people could think about with respect to what Jack was bringing up as we go downstream.

Ralph, I don't think it's fair to say that the extra costs of teaching hospitals that are somehow not associated with residents are not in this mix. I think the easiest way to see this is suppose we computed the costs of teaching hospitals by taking out the resident salaries as we do now and saying that's direct medical education.

And then we've got a cost per case for teaching hospitals and we've got a cost per case for non-teaching hospitals. And we'll just take the means. And those means will be different and we'll call that the extra cost of patient care of teaching hospitals.

That's a variant, in fact, of what we do now. Instead we have this continuous measure of residents that we say the cost -- instead of having two groups we have teaching hospitals that have a few residents, teaching hospitals that have lots of residents. The costs per case are different in each group and, in effect, we just have lots of groups of hospitals of varying intensity.

But all of the costs of patient care at those hospitals are in what we're computing. So at the end of the day the empirical level does include all of those costs. So

I think it's not fair to say there's not a subsidy there.

On Jack's thrust, I personally have some problems with Medicare support as appropriate, as I said yesterday. So I'm more in the if there is going to be the subsidy it should be conditional. But then I think my problems are somewhat like Carol's. If it's to strengthen education, I don't think we know how to do that very well and I think it opens up a whole raft -- particularly once you get beyond MDs.

What about training of pharmacists, for example? I think that goes on outside hospitals that now get these subsidies. How do we handle that? How do we decide how much money is in this pot? And how does it get distributed? I mean, we have the money distributed now by residents per bed, for better or for worse. It's not clear that that's the right mechanism to distribute the new thing. It sounds much more like, as Carol said, a kind of apply for grant program. But that makes Medicare funding, in some ways, even less appropriate. It sounds like something for general revenues to me.

I don't have answers to this, but I think that, in trying to put forward what I'll call a conditional subsidy -- that is you get the subsidy if you meet certain conditions -- in thinking about this, we're going to have to solve the how do we think about how much money and how does it get distributed? And does it get distributed to hospitals that don't now have residence because they potentially qualify for some initiatives in this domain?

MR. HACKBARTH: We don't have time this morning to engage in the specifics of the debate. What I do hear is broad consensus among the commissioners on three basic points. One, there is not complete satisfaction with the status quo. That we ought to at least explore possibilities for improved targeting of the dollars to some new purposes. But three, the exact way to do that -- or even whether it can be done -- is not entirely clear right now.

And so that's where I would like to leave it for right now. We will draft some language for commissioners to review and in then we'll figure out a plan for how to come back and grapple with this issue.

Jack, thank you for the additional work you did on this last night. And how we need to move on to today's agenda.

DR. REISCHAUER: I just want say something while Sally's setting up that really goes to the way we, as commissioners, discuss issues like this. Several times today and yesterday, and certainly those contributing to the public comments, have referred to the IME recommendation as

the staff's recommendation. And I think we shouldn't use that term.

These recommendations come out of analysis which the staff does, our reaction over three or four meetings. These are the commission's draft recommendations or the chairman's mark, if you want. There isn't a gap between the staff and the commissioners, in any sense. They're our agents and doing a heck of a good job trying to condense our thinking about this.

And so I'd appreciate it if we referred to these as our draft recommendations rather than the staff's.

MR. HACKBARTH: Okay, today we begin with the PPS for psychiatric facilities. Sally.

* DR. KAPLAN: Thank you. Good morning.

In this presentation I'll briefly present some information about psychiatric facilities and then I'll focus on the issues CMS needs to consider when developing the PPS. We raised these issues in our letter to the Congress which will go to the Congress at the end of this month.

To review the chronology, the BBRA requires CMS to do two things about a PPS for inpatient psychiatric care. First, to design a PPS that would pay on a per diem basis, and to report on the PPS to the Congress.

MedPAC is required to evaluate the impact of the PPS on which CMS reports. In other words, we're required to report on their report.

CMS issued their report in August, 2002. Our report is due to the Congress March 1. However to be more useful to CMS and the Congress, we plan to submit a letter in January.

I want to make it clear that our letter is targeted or is based on the report that CMS made to the, Congress. The proposed rule, which is scheduled to come out probably in March or the end of March, may be different than what was described in this report and we don't know whether it is or it isn't but it may be. And our report to Congress is based on CMS's report. So I just want to clarify that.

When CMS actually publishes the regulation on the PPS, we'll comment on their proposal and I think we can be more helpful after we see what they're actually proposing.

Once the PPS is implemented, we'll suggest refinements as necessary as part of our regular work, as we do with all of the PPS'.

Some basic volume and spending figures for 2000 on the screen. You've seen these before. About 300,000 beneficiaries received care in 2000. The majority of these beneficiaries were disabled. Some had more than one discharge. Medicare spends about $3 billion a year on

beneficiaries who use these facilities. There are about 2,000 psychiatric facilities that are Medicare certified and 75 percent of these are hospital-based units.

This is a map that you've seen before. The red dots represented the government-owned hospitals. The blue dots represent the other freestanding hospitals. And the green dots represent the hospital-based units.

Another way to look at the distribution of facilities is by region and by type of facility. The table on the screen gives you that distribution. We show census region by percentage of hospital-based units, government-owned freestanding facilities, and other freestanding facilities, and also the total by region.

Other questions you've had about the distribution of facilities and the Medicare case load by facility type.

As you can see on the screen the majority of beneficiaries are treated in hospital-based psychiatric units. About 6 percent of patients are treated in government-owned hospitals.

To briefly review, the model described that was developed by The Economic and Outcomes Research Institute, or ThEORI, collaborating with the American Psychiatric Association -- we call this the APA model for simplification purposes. It uses regression coefficients from a model that relates per diem resource use for beneficiaries to the patient and facility characteristics available from CMS administrative data.

Examples of patients variables are principal diagnosis, secondary diagnoses, and age. Examples of facility variables are location in overall area or the extent of teaching activity. The regression model explains 20 percent of the variation in per diem resource use among beneficiaries.

During our analysis of the APA model we identified six major issues that break down into three broad categories of issues: determining appropriate payments, implementation and administration, and system design and statistical methods.

To determine appropriate payments for inpatient psychiatric care, we believe CMS needs to do additional work. CMS found differences between hospital-based and freestanding psych facilities and they attributed the difference to patients transferred from acute care hospitals with still unresolved medical problems. However, only 21 percent of the patients treated in units have had an acute hospital stay in the previous month.

CMS will need to examine more fully the differences between hospital-based and freestanding

facilities to determine how much of the difference in costs is related to cost allocation issues or to differences in patient complexity. Ideally, the payment will follow the patient and properly reimburse the facilities regardless of whether it is hospital-based or freestanding.

The other issue regarding determining appropriate payments has to do with government-owned hospitals. We prefer that the government-owned hospitals be included in the PPS. As you saw in the earlier slide, government-owned psychiatric hospitals treat only 6 percent of Medicare beneficiaries but these hospitals function as safety nets, admitting patients other facilities will not admit. These hospitals have lower costs per day than other facilities but we don't know why.

CMS will need to explore further the differences among patients treated in different types of facilities and the cost of their care to determine appropriate payments. We also plan to do further work on this issue so that we can comment more fully on the proposed rule.

We identified two implementation and administration issues. The first is a little more complex than the second. The implementation issue has to do with the transition to the PPS. A gradual transition would allow facilities that have relatively generous payments under the current system time to adjust to the PPS. An option for facilities to move to 100 percent PPS payment before the transition is complete would allow facilities who have relatively low payments under the current system to benefit from the PPS immediately.

Ideally, having a slow transition coupled with an option for facilities to move to full PPS payments immediately protects the provider infrastructure. CMS will need to estimate the number of facilities that are likely to take the 100 percent option because the base rate will still need to be budget neutral.

When considering the length of the transition and the effective of 100 percent option, CMS will need to balance these two policies to make sure that no group of facilities is overly penalized by the policy choices made.

The second issue has to do with updating payments. Currently it's silent on updating payments to psychiatric facilities. Providing the secretary with authority to update payments annually and adjust for case-mix creep is needed will ensure the most efficient implementation and administration of the new PPS.

Finally, we move to two relatively technical issues, one on structuring per diem payments and one on per diem costs. The APA model uses what is called declining

block pricing for the PPS. This system sets per diem payment rates for blocks of days where payments decline as the stay gets longer. For example, facilities would be paid higher rates for the first two days of the stay. They would be paid 84 percent of that rate for day three through eight. The rates would continue to step down thereafter. Because rate blocks create cliffs, we suggest that per diem payments decrease continuously, resulting in a smoother decline in rates. This avoids financial incentives associated with cliffs.

The second issue has to do with the fact that CMS has commonly transformed costs into logarithmic values in designing payment systems. New empirical evidence suggests that models using large samples of raw values produce more reliable estimates than transformed values. The database used to construct the psychiatric payment model has a very large sample, about 400,000 observations. Therefore we suggest that CMS explore both logged and unlogged cost variables.

That completes my presentation.

MR. HACKBARTH: Questions or comments?

DR. NEWHOUSE: So I'm right in remembering that the APA model left out government facilities?

DR. KAPLAN: The original APA model did and then when they added them in based on what was said in the report, and that showed that the government facilities got 18 percent payment, an increases 18 percent in payments, compared to the current system.

DR. NEWHOUSE: The question I was going to raise, has there been any thought given, to your knowledge, of the crowd out issue? That is if we give more to government facilities, the state and local governments will reduce support potentially?

DR. KAPLAN: I'm not sure but we can certainly raise that issue.

MR. HACKBARTH: Others?

DR. MILLER: I just want to mention a couple of things quickly. Two, I think, are just things I want to change a little bit in the tone of the letter. We said consistently throughout all of our meetings that we're commenting on this before the reg comes out in order to try and be helpful. We've been very clear about that. I think we just actually need a sentence or so in the letter saying that's what's going on.

A second thing, I think we characterized throughout the letter, this is CMS's model. And the same vein, they haven't proposed it yet in March. We know this is going to be the basis of it but we'll just refer to it a

bit differently. I don't think this really makes a big difference.

The last point, which I just want to reinforce, is we're going to add a sentence or so based on something that Sally just said there. When the Secretary looks at the transition going to allowing people to move to 100 percent of PPS we just want to be sure that inside the budget neutral framework that's done in a way that doesn't create a lot of disparities between the facilities. She said that. I just want to be sure that that sentence gets in there.

DR. REISCHAUER: Sally are the government-owned facilities largely caring for Medicaid financed patients and very long-term patients?

DR. KAPLAN: I think what were going to be doing in part of our work is to really understand what's going on in the government hospitals. The work that CMS did showed that they have an average length of stay that's much longer but it isn't clear to us whether all patients or most patients in government hospitals have very long lengths of stay compared to the other facilities. And that's one of the things that we're going to be looking at. So I hope to be able to answer your question more fully when we comment on the proposed rule.

MS. DePARLE: I'm mulling this because I had trouble hearing. At the beginning you said something about the new payment system explaining only 20 percent of the variation or something. Could you restate that?

DR. KAPLAN: Yes, it explains 20 percent of the variation in per diem costs per patient.

MR. HACKBARTH: Could you put that in context? How does that compare with some of the other PPS systems?

MS. DePARLE: That strikes me as little bit low.

DR. KAPLAN: But you're taking out the variation that's due to length of stay when you go to a per diem system. So it's not necessarily comparable to your hospital PPS where you're talking about a per case system.

MS. DePARLE: So in your view -- I mean, you've raised other concerns, but is that piece of it adequately predictive at this point?

DR. KAPLAN: We think that it is. We don't think this model is perfect or fabulous but we think that this may be the best that can be done with the information that's available at this time. And we do think that the current system that the hospitals are under, and have been under for 20 years, is a problem.

DR. MILLER: Can I just ask one more thing along these lines? Has anyone looked at how it explains the variation at the hospital level? Because we're talking

about the per diem level -- or the facility level. Because again, once you start aggregating, more of the variation might be explained. So that's something else we can try and look at.

DR. KAPLAN: We can add that to the agenda.

DR. STOWERS: Sally, I mentioned geri-psych last month. It's a little difficult to ask this question but you have the long-term psych patients that are there longer. And then you have the geri-psych that primarily come in, it's usually their first episode, it's usually a one-time stay, relatively short, a week or two, where you're trying to differentiate I would say a medical diagnosis versus a psych. So you may do the scans and medical workup, rule out diabetes and the other things. And then you stabilize on whatever medicine they need and then send them back to long-term care or home or whatever. But there's a significant medical component to those shorter, more intensive, stays in these older patients.

How is that medical part accounted for? Or do we use the medical PPS to add onto these? I'm just curious because it's really not explained how that works.

DR. KAPLAN: There are two ways that that is taken into account. First of all, there's a variable for age, patients that are over 65, and the coefficient is higher for those people. In other words there's additional money put in for patients who are over 65.

In addition, CMS uses comorbidities. Now, in the proposed rule, they only talked about four comorbidities. But I think we need to see what the actual proposed rule -- I mean, in the report they only talked about four comorbidities, but in the proposed rule they may have changed that somewhat. And I think that's something we can weigh in on that.

DR. STOWERS: Usually what's happening here is you have the psychiatrist or their staff doing the psychological workup. And then you have the primary care physician or internist or whatever doing a complete medical work on the patient at the same time. I mean, that's the norm. So just be sure we're accounting for all of that medical workup that occurs in those people. If I'm making sense.

DR. NEWHOUSE: That would be Part B, on the physician side.

DR. STOWERS: I think I'm talking more about what they order because it's very common to do the scans, CTs, and that kind of thing to rule out tumors or other things.

DR. NEWHOUSE: It would still be Part B, wouldn't it?

DR. STOWERS: I'm not sure. It may be, even

though they're in patients. I wasn't sure.

MR. HACKBARTH: Anybody else? Okay, thank you, Sally.